STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155224	A. BUILDING 00 B. WING	01/24/2013

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COLUMBIA HEALTHCARE CENTER	621 W COLUMBIA ST EVANSVILLE, IN 47710

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F0000	This visit was for the Investigation of Complaint IN00122655. Complaint IN00122655 Substantiated, Federal/State findings related to the allegations are cited at F315, F325, and F514. Unrelated deficiency is cited. Survey dates: January 22, 23, and 24, 2013 Facility number: 000129 Provider number: 155224 AIM number: 100266780 Survey team: Anne Marie Crays RN Census bed type: SNF/NF: 156 Total: 156 Census payor type: Medicare: 29 Medicaid: 108 Other: 19 Total: 156 Sample: 5	F0000	We request a face to face IDR on F315 and F 325The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Post Survey Revisit on or after February 7,2013	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review was completed on January 28, 2013, by Jodi Meyer, RN			

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F0155 SS=D	483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section. Based on interview and record review, the facility failed to ensure advanced directives regarding resuscitation status were documented accurately and consistently throughout the clinical record, for 2 of 3 residents reviewed with advanced directives, in a sample of 5. Residents B and C Findings include: 1. On 1/22/13 at 10:45 A.M., the Administrator provided a list of residents, indicating those who were alert, oriented, and interviewable. Resident B was not indicated as being interviewable. The paper clinical record of Resident B was reviewed on 1/24/13 at 10:30 A.M. An "Adult Resuscitation Order," dated 1/2/13, indicated, "In the event of Cardiac and/or Pulmonary Arrest: Full Resuscitation...." Physician recertification orders, initially dated 10/31/12 and included in the	F0155	F155 **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** ·Resident B is a full code and this is appropriately reflected in the medical record. The MAR, physician orders and face sheet appropriately indicate the resident code status. ·Resident C no longer resides in the facility. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** ·All residents have the potential to be affected by the alleged deficient practice. DNS/SSD/designee has audited every resident chart on or before February 7 th , 2013 to ensure advanced directives are accurately reflected on every area of the chart required including physician orders, yellow sheets when appropriate, face sheet and the MAR. Any clarifications or discrepancies will be reported immediately to the DNS/designee and family or appropriate party will be notified and correct	02/07/2013

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	January 2013 orders, indicated, "DNR" [do not resuscitate]. A face sheet in the electronic medical record indicated Resident B was a full code. On 1/24/13 at 10:30 A.M., during interview with LPN # 1 and LPN # 2, each nurse indicated if a resident was in distress, they would check the resident's paper clinical record and/or the MAR [medication administration record] to determine if a resident was a DNR. LPN # 1 checked Resident B's MAR at that time. A code status was not included on the MAR. LPN # 1 and LPN # 2 then indicated the resident had been at the hospital recently, and perhaps the code status was on the hospital transfer paper. The hospital transfer paper, dated 1/5/13, indicated "Code Status" and the form was left blank. At that same time, the downstairs Unit Manager indicated she would investigate the situation. On 1/24/13 at 10:50 A.M., the Medical Records manager provided unsigned physician's orders, dated "1/5/2013 through 1/31/2013." The orders included, "Code Status: Full Code." The Medical Records manager indicated she had the orders in her office waiting for the physician to sign them. The Medical		advanced directives will be documented. Residents and Families will be counseled on advanced directives upon admission, at every care conference and as SSD/DNS/designee find appropriate and any changes will be reported to SSD/designee for follow up review of appropriate documentation regarding change of code status. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Residents and Families will be counseled on advanced directives upon admission, at every care conference and as SSD/DNS/designee find appropriate and any changes will be reported to SSD/designee for follow up review of appropriate documentation regarding change of code status. SDC/DNS/SSD/designee provided education to nurses regarding advanced directives and notification of change to SSD for follow up. IDT will review resident code status at re-admission and significant change to ensure all documentation is consistent with resident desired code status. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur?** DNS/SSD/designee will utilize Advanced Directive/Code Status CQI tool	

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	Records manager indicated there should have been a pink copy of the orders in the clinical record for staff. On 1/24/13 at 11:45 A.M., during interview with the Administrator, she indicated the code status was correct in the computer, and nursing staff should check the computer record to determine code status. 2. The closed clinical record of Resident C was reviewed on 1/23/13 at 2:00 P.M. Physician recertification orders, initially dated 1/15/08 and on the December 2012 and January 2013 orders, indicated, "Full Code." A "State of Indiana Out of Hospital Do Not Resuscitate Declaration and Order," dated 10/24/12, indicated the resident's responsible party and physician signed a DNR declaration. On 1/24/13 at 11:45 A.M., during interview with the Administrator, she indicated the policy regarding DNR and Full Code status had changed last fall, and the staff who received the DNR declaration should have written an order. 3. On 1/24/13 at 11:15 A.M., the Social Services Director provided the current		weekly x 4weeks and monthly for at least 6 months and all new admissions will be reviewed by IDT to ensure proper documentation of advanced directives. **Compliance date: February 7 2013**	

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	facility policy on "Advanced Directives...," revised 1/06. The policy included: "...Facility shall determine if the Qualified Resident has completed an Advance Directive indicating his/her wishes concerning cardio-pulmonary resuscitation ('CPR'). If so, a copy of the Advance Directive/consent shall be maintained in the resident's medical record...Facility shall then make the appropriate chart entries...indicating to staff that resident is 'DNR' or 'No Code'...." 3.1-38(f)			

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F0315 SS=G	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Based on observation, interview, and record review, the facility failed to ensure a foley catheter drainage bag and tubing was kept off of the floor, resulting in the resident requiring antibiotics for a urinary tract infection, for 1 of 1 residents reviewed with foley catheters, in a sample of 5. Resident A Findings include: 1. On 1/22/13 at 12:20 P.M., Resident A was observed lying in a low bed, asleep. A foley catheter bag, in a blue protective cover, was observed lying on the floor. On 1/22/13 at 2:25 P.M., Resident A was observed sitting up in bed, eating. A foley catheter bag, outside of the blue cover, was observed lying on the floor. The side of the bag with the outlet valve was on the	F0315	We request a face to face IDRF315 **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** ·Resident A has been placed in a low bed that is not lowered completely to the floor therefore allowing appropriate space for the catheter bag to hang properly without touching the floor. ·Catheter care is given per policy **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** ·All residents with a catheter have the potential to be affected by the alleged deficient practice. DNS/SSD/designee have assesed every resident with a catheter on or before February 7 th , 2013 to ensure compliance with catheter care and that chairs and beds frequently used have	02/07/2013

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	floor. The blue cover was hanging on the bed frame. On 1/23/13 at 8:30 A.M., Resident A was observed lying in a low bed, asleep. A foley catheter bag in a blue protective cover was hanging on the bed frame, lying on the floor. The clinical record of Resident A was reviewed on 1/23/13 at 8:45 A.M. Diagnoses included, but were not limited to, kidney disease, dementia, and urinary retention. Physician orders, initially dated 9/10/12 and on the January 2013 recertification orders, indicated, "Foley Catheter care every shift," and "16 Fr [French foley catheter] to BSD [bedside drainage] Dx [diagnosis] Neurogenic Bladder." A Minimum Data Set [MDS] assessment, dated 12/9/12, indicated the resident scored a 4 out of 15 for cognitive status, with 15 indicating no memory impairment. The MDS assessment indicated the resident required extensive assistance of two + staff for bed mobility, transfer, and was totally dependent on two + staff for toilet use. A Care Plan, dated 9/20/12, indicated: "Problem, Resident requires an		designated and appropriate places to hang catheter bags that will enable bags to hang without touching the floor and that bags are covered appropriately. DNS/SDC/designee have educated staff by February 7 th on proper placement of catheter bags and catheter care policy. Nurses have had additional education on preventing infection as it relates to catheter care. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** DNS/SSD/designee have assessed every resident with a catheter on or before February 7 th , 2013 to ensure compliance with catheter care and that chairs and beds frequently used have designated and appropriate places to hang catheter bags that will enable bags to hang without touching the floor and that bags are covered appropriately. DNS/SDC/designee have educated staff by February 7 th on proper placement of catheter bags and catheter care policy. Nurses have had additional education on preventing infection as it relates to catheter care. DNS/nurse managers/designee will conduct rounds to ensure foley catheter drainage bag and tubing is kept off of floor daily on all shifts.**How the corrective action(s) will be monitored to ensure the deficient practice**	

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	indwelling urinary catheter R/T [related to]: urinary retention and neurogenic bladder...Approach...Do not allow tubing or any part of the drainage system to touch the floor...Store collection bag inside a protective dignity pouch." On 1/23/13 at 1:20 P.M., during interview with the Administrator, she indicated the foley catheter bag should not be placed on the floor. On 1/24/13 at 10:55 A.M., during interview with the interim Director of Nursing, she indicated she had just received an order for an antibiotic for Resident A, due to a UTI [urinary tract infection]. The clinical record of Resident A was reviewed again on 1/24/13 at 2:30 P.M. A physician's order, dated 1/24/13 at 10:50 A.M., indicated, "Cipro [antibiotic]...for 10 days d/t [due to] cloudy, foul smelling urine [and] malaise." 2. On 1/24/13 at 2:20 P.M., the Administrator provided the current facility policy on "Indwelling Urinary Catheter," reviewed 12/2012. The policy included: "...Place drainage bag below level of bladder. Do not place bag on side rail or on bed...." The policy did not include specifically not placing the		**will not recur?** DNS/SSD/designee will visually monitor all catheter bags to ensure bags are covered properly and not touching the floor daily x 14 days, weekly x 6 weeks and monthly for at least 6 months. DNS/SDC/designee will utilize Catheter assessment CQI tool monthly for at least 6 months. All nursing staff will continue to be educated during this time for constant monitoring of the appropriate catheter care practices. · Any need for additional training will be reported to ED. ·All audit tools will be brought before the CQI committee monthly ·Any non-compliant issues may be addressed with re-education and/or disciplinary action. **Compliance date: February 7 2013**	

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	drainage bag on the floor. This federal tag relates to Complaint IN00122655. 3.1-41(a)(1) 3.1-41(a)(2)			

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F0325 SS=G	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. Based on observation, interview, and record review, the facility failed to ensure accurate weights were obtained and recorded, thereby failing to provided interventions to prevent weight loss, for 2 of 3 residents reviewed for weight loss, in a sample of 5. Resident A, Resident C Findings include: 1. On 1/22/13 at 9:50 A.M., during the initial tour, the interim Director of Nursing [DNS] and the 2nd floor Unit Manager indicated Resident A had experienced a weight loss in the previous 2 months. On 1/22/13 at 2:25 P.M., Resident A was observed sitting in bed in his room, eating	F0325	We request a face to face IDRF325 **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** ·Resident A was placed on weekly weights in January. Additional care plan measures were also in place per Registered Dietician assessment and recommendations. Resident A weight has stabilized x 3 weeks. ·Resident C no longer resides in the facility. **·All scales have been tested and calibrated by equipment vendor** **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** ·All residents have the potential to be affected by the alleged deficient practice. DNS/RD/designee have	02/07/2013

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	a piece of pizza left from lunch. The clinical record of Resident A was reviewed on 1/23/13 at 8:45 A.M. The resident was admitted to the facility on 9/9/12 with diagnoses including, but not limited to, dementia and diabetes mellitus. Physician orders, dated 9/9/12, indicated Resident A was on a CCHO [concentrated carbohydrate] diet. An admission Minimum Data [MDS] assessment, dated 9/16/12, indicated the resident scored a 3 out of 15 for cognitive status, with 15 indicating no memory impairment. The MDS assessment indicated the resident required limited assistance of one person for eating, and his weight was 165 lbs. A Care Plan, dated 9/17/12 and discontinued on 1/22/13, indicated: "Problem, Resident requires a therapeutic diet related to dx [diagnosis] of DM [diabetes mellitus]. Goal, Resident will not display significant weight loss through next review. Approach, meal is consumed [sic], Provide diet per MD order, Review labs as available." Speech therapy treatment notes included the following notations:		assessed every resident with weight loss and RD recommendations have been implemented. RD and DNS/designee with IDT meet weekly for NAR (Nutritionally at Risk) to update care plans as necessary for at risk residents. DNS/SDC/designee have educated staff by February 7 th on proper meal consumption policies and consistent weight procedures. DNS/ED/RSM have educated therapy staff to encourage continued communication with Nursing/Dietary departments regarding nutrition concerns of residents to enhance optimal functional ability. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** DNS/RD/designee have assessed every resident with weight loss and RD recommendations have been implemented. RD and DNS/designee with IDT meet weekly for NAR (Nutritionally at Risk) to update care plans as necessary for at risk residents. DNS/SDC/designee have educated staff by February 7 th on proper meal consumption policies and consistent weight procedures. DNS/ED/RSM have educated therapy staff to encourage continued communication with Nursing/Dietary departments	

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	11/5/12: "Pt [patient] reportedly eating sweets for nutrition all day and not consuming any dietary offerings. Unbalanced meals or refusal of balanced meals leads to poor health, overall body weakness, and unsafe/weakened swallow when appropriate appetite does improve...." 12/3/12: "Pt continues to eat a very poorly balance [sic] diet, at this point. Most meals aren ' t' even consumed. He tends to snack on candy and dessert off and on throughout the day when he is hungry rather than eat what is offered by dietary...SLP [speech language pathologist] approached the 1st shift nurse concerning an appetite enhancing drug. After discussion, therapist investigated possible wt. [weight] loss. According to the past 2 1/2 to 3 months of his residency in current nursing facility, he has gained 6 lbs not lost...." 12/4/12: "Continue to brain storm with 1st shift nurse concerning swallow, nutrition and motivation to improve his current appetite...It is difficult to treat his swallow when he barely eats his meals...Pt has not lost wt in past couple of months, so an appetite enhancing drug would not be appropriate...."		regarding nutrition concerns of residents to enhance optimal functional ability. Speech Therapy staff will also attend NAR meeting on a regular basis. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur?** DNS/RD/designee will monitor weights per policy and implement needed changes as resident condition dictates. DNS/RD/IDT/designee will meet weekly for NAR and provide findings to CQI committee monthly. All scheduled weights will be monitored by RD/DNS/IDT during weekly Nar meeting and re-weights will be performed as indicated. RD recommendations will be given when appropriate and DNS/RD/designee will use CQI tool to monitor interventions and programs utilizing CQI tool weekly x 4 and monthly for at least 6 months and report findings to CQI committee monthly. **Compliance date: February 7 2013**	

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	A dietary progress note, dated 12/6/12 at 2:14 P.M., indicated, "...Resident on consistent carbohydrate diet per order. On average resident consumed 50% B [breakfast]/100%L [lunch]/100%D [dinner] of meals recorded in the consumption record over the last 7 days...Weight 162 lbs (11/12)...No new recommendations at this time." A Speech therapy note, dated 12/7/12, indicated: "...He admits he has a poor appetite for bldg [building] food and likes to eat snacks/candy instead. There have been days when he has been observed eating 60-75% of his meal in the past two weeks...." Nursing progress notes, dated 12/8/12 at 2:28 A.M., indicated, "...Alert and oriented with periods of confusion at times...Eats meals in his room per his request and feeds self...." Nursing progress notes, dated 12/17/12 at 10:04 P.M., indicated, "...Feeds self with tray set up...." Nursing progress notes, dated 1/1/13, indicated, "...Feeds self with set up eats in room per request...." A dietary progress note, dated 1/13/13, indicated, "January wt [weight] 132 #			

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	[lbs] - this is down 19% x 30 days. Meal intakes 0-50%. Spoke with nursing who reports rsd [resident] refusing to eat at times. Rsd typically consumes 51-100% of meals...Recommend change diet to regular, 7.5 mg Remeron [appetite stimulant] daily. Will add to weekly wts." A Care Plan, dated 1/22/13, indicated, "Problem, Resident has experienced significant weight loss x 30 days. Goal, Resident will not experience further significant weight loss...." On 1/23/13 at 10:00 A.M., during interview with the Registered Dietician [RD], Administrator, and MDS Coordinator, the Administrator indicated they had identified a problem with the facility weights. The RD indicated she started at the facility on 12/17/12, and when the January weights were obtained, the RD notified the Administrator the facility appeared to have more residents with weight loss than they had ever had previously. The Administrator indicated the previous system for weights were for 1 restorative aide to obtain the monthly weights, and then would give them to the previous DON to be entered into the computer. The Administrator indicated she was unsure if the previous DON was entering the correct weights, in order to minimize weight loss. The Administrator			

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	indicated she did not think Resident A had lost 30 lbs in 1 month, but maybe had had a gradual weight loss. The RD indicated it was unclear if the resident had first been weighed with his prosthesis on, but that would have been only a 6 lb difference. The Administrator indicated a new system for recording and entering weights was now in place. 2. On 1/22/13 at 10:25 A.M., during interview with a family member of Resident C, she indicated she was very surprised to know that her mother had lost so much weight since last fall. She indicated she visited her mother approximately every 2 weeks, but that her mother was usually covered up, and she did not notice the weight loss. The closed clinical record of Resident C was reviewed on 1/24/13 at 2:00 P.M. Diagnoses included, but were not limited to, dementia, non-insulin dependent diabetes mellitus, congestive heart failure, and Parkinson's disease. Physician orders, initially dated 2/6/12 and on the January 2013 recertification orders, indicated, "Regular diet with thin liquids." An additional order, dated 12/6/12, indicated, "Double portein [sic] at breakfast."			

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	A MDS assessment, dated 9/25/12, indicated the resident was unable to complete a test for cognitive status, required extensive assistance of 1 staff for eating, and weighed 145 lbs. A MDS assessment, dated 12/5/12, indicated the resident was unable to complete a test for cognitive status, required extensive assist of 1 staff for eating, and weighed 140 lbs. A dietary note, dated 12/6/12 at 1:52 P.M., indicated, "...Resident is on a regular diet with thin liquids per order. On average resident consumed 75% B/ 63% L/ 50% D; weight 140 lbs (11/12)...Recent abnormal pertinent lab values as of 12/4...Recommend double protein at breakfast r/t [related to] low albumin level and best intake being at breakfast meal." A Care Plan regarding weight loss was not located in the clinical record. The resident was transferred to the hospital on 1/7/13 at 5:00 P.M. due to lethargy. On 1/23/13 at 2:30 P.M., the Administrator provided a weight report for Resident C, which indicated the resident's weight on 11/12/12 was 140			

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	lbs, and on 12/11/12 was 142 lbs. The Administrator indicated there was no January weight, because the resident had been discharged on January 7, and the weights weren't due to be completed until the 11th of the month. On 1/24/13 at 9:15 A.M., admission hospital records were reviewed. The resident's weight was documented as 120 lbs on 1/7/13 at 5:29 P.M. The resident had lost 22 lbs since 12/11/12. On 1/24/13 at 12:00 P.M., the Administrator provided a written weight record for January, undated. The Administrator indicated the record was from the restorative aide. The record indicated Resident C's weight was 136 lbs. The Administrator indicated she did not know the date of the weight, but that it was not recorded due to the resident being transferred to the hospital on 1/7/13. The Administrator indicated she could not explain the 16 lb weight difference, but that perhaps the hospital utilized a different scale. The Administrator indicated the facility was using a different system now for recording the residents' weights. 3. On 1/23/12 at 1:20 P.M., the Administrator provided the current facility policy on "Resident Weights,"			

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	dated 3/10. The policy included: "A monthly weight log is sent to the following individuals by the [blank] day of the month: Director of Nursing, Registered Dietician, Dietary Services Manager, MDS Coordinator...." This federal tag relates to Complaint IN00122655. 3.1-46(a)(1)			

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F0514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on interview and record review, the facility failed to ensure documentation regarding the frequency of bowel movements was accurate, for 1 of 4 residents reviewed for documentation, in a sample of 5. Resident A Findings include: 1. The clinical record of Resident A was reviewed on 1/23/13 at 8:45 A.M. An electronic "Vitals Report" dated 1/1/13 to 1/23/13, indicated the resident had a bowel movement on 1/1, 1/2, 1/7, 1/8, 1/20, 1/21, 1/22, and 1/23.	F0514	F514 **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** ·Resident A documentation has been reviewed to ensure proper bowel movement documentation has occurred. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** ·All residents have the potential to be affected by the alleged deficient practice. ·DNS/SDC/designee have provided education by February 7 th to all nursing staff regarding documentation requirements related to bowel management. ·All charts have been audited through bowel management report to ensure proper	02/07/2013

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	On 1/23/13 at 9:50 A.M., during interview with the 2nd floor Unit Manager, he indicated bowel movements were recorded each shift on the Vitals Report. He indicated a report was printed out daily which indicated which residents had not had bowel movements for 3 days, and this report was reviewed by the nursing staff. He indicated there was no other location he could think of which recorded bowel movements. On 1/23/13 at 1:20 P.M., during interview with the Administrator, she indicated staff should be documenting bowel movements every shift on the Vital Signs page. She indicated the Minimum Data Set coordinator had indicated there was another location in which CNAs may be documenting bowel movements. The Administrator indicated it was not the right location, and staff would have to be reinserviced. 2. On 1/23/13 at 1:20 P.M., the Administrator provided the current facility policy on "Bowel Elimination," dated 6/2012. The policy included: "...Bowel movements will be recorded on the facility EMR [electronic medical record] and/or record daily by the direct care staff. The DNS [Director of Nursing Services]/designee will assign a charge		documentaton DNS/SDC/designee review bowel management report 5x per week to ensure proper documentation. Any missing documentation is promptly brought to assigned staff for clarification/education and possible disciplinary action when warranted. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · DNS/SDC/designee have provided education by February 7 th to all nursing staff regarding documentation requirements related to bowel management. DNS/SDC/designee review bowel management report 5x per week to ensure proper documentation. Any missing documentation is promptly brought to assigned staff for clarification/education and possible disciplinary action when warranted. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur?** DNS/SDC/designee review bowel management report 5x per week to ensure proper documentation. Any missing documentation is promptly brought to assigned staff for clarification/education and possible disciplinary action when warranted. CQI tool will be used by DNS/designee weekly x4 then monthly for at least 6 months· Any need for additional training will be reported to ED.	

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	nurse on a specific shift to review all BM Records on a daily basis...." This federal tag relates to Complaint IN00122655. 3.1-50(a)(1) 3.1-50 (a)(2)		·All audit tools will be brought before the CQI committee monthly ·Any non-compliant issues may be addressed with re-education and/or disciplinary action. **Compliance date: February 7 2013**	